



December 5, 2022

Chiquita Brooks-LaSure
Administrator
Medicare & Medicaid Services
Department of Health and Human Services,
Attention: CMS-0058-NC
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Request for Information; National Directory of Healthcare Providers & Services

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association, I write in response to the request for information (RFI) regarding various aspects of the potential National Directory of Healthcare Providers and Services (NDH) and to express support for this initiative.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 223,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

More than 90,000 ASHA members work in health care practice settings including acute care, inpatient rehabilitation facilities (IRFs), long-term acute care hospitals (LTACHs), skilled nursing facilities (SNFs), outpatient clinics, pediatric hospitals, home health, and private practices.¹ Therefore, they want to ensure that consumers are aware of and have easy access to a current directory of health care providers, including audiologists and speech-language pathologists.

ASHA appreciates the comprehensive nature of this RFI, including health equity and the many clinical and technical facets that a project of this magnitude requires. ASHA offers the following recommendations to assist CMS in establishing a national health care directory benefiting both beneficiaries and the providers who serve them.

What benefits and challenges might arise while integrating data from CMS systems (such as NPES, PECOS, and Medicare Care Compare) into an NDH?

ASHA foresees several benefits to a national health care directory for patients, providers, and the administrative efficiency of the health system.

An NDH would allow patients to find qualified providers quickly and easily in their area, ascertain if the provider's skills and experience are a fit for their needs, and determine whether the provider is in-network or out-of-network for their health plan. This translates to a simplified and improved patient experience with time saved and increased patient satisfaction.

From a provider standpoint, an NDH would simplify the often burdensome process of maintaining multiple directory listings and frequent re-attestation for credentialing; help address the disconnect between patients' needs and providers' skills; and support interoperable data exchange. ASHA supports the NDH as a replacement for the current reality of multiple disparate

systems but cautions against its mere addition to the already lengthy list of directories because that would further decrease efficiency and increase provider burden.

A central depository of provider information could expedite the prior authorization process and facilitate interprofessional collaborative practice. Prior authorization, often employed as a utilization management technique, can delay or deny much needed care to beneficiaries. A comprehensive NDH could reduce the time, cost, and effort required for payers to reach providers for prior authorization and supplemental documentation needs. The NDH could also ease communication between health care team members affiliated with different facilities and/or health systems.

ASHA is aware of the potential for technical and security challenges and recommends that these issues be addressed prior to the initiation of provider data collection. Provided that these concerns are accounted for, ASHA supports this initiative and the goals of improved patient and provider experience, interoperability, and the time and cost savings of reducing administrative friction.

Are there other CMS, HHS (for example, HPMS, Title X family planning clinic locator, ACL's Eldercare Resource Locator, SAMHSA's Behavioral Health Resource Locator, HRSA's National Practitioner Data Bank, or HRSA's Get Health Care), or federal systems with which an NDH could or should interface to exchange directory data?

An ideal NDH would be capable of pulling and updating provider data from existing systems to reduce provider and administrative burden. The identity management portal Healthcare Quality Information System (HCQIS) Access Roles and Profile (HARP) is connected to multiple CMS applications and could serve as the foundation for a robust central database.

The National Provider Identifier (NPI) system, which is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard, is a system most providers are familiar with and could supplement or be incorporated into HARP data. Claims data may be another source to populate the system with providers who are currently billing for their services. ASHA recommends creating a system that allows providers to opt-out instead of opt-in to maximize the robustness and utility of the NDH.

ASHA maintains an extensive database called ASHA ProFind that includes over 20,000 ASHA-certified audiologists and speech-language pathologists who have indicated they are accepting referrals. ASHA ProFind could serve as a data source for NDH to serve individuals seeking hearing, speech, language, cognition, and swallowing services.

Are there systems at the state or local level that would be beneficial for an NDH to interact with, such as those for licensing, credentialing, Medicaid provider enrollment, emergency response (for example, the Patient Unified Lookup System for Emergencies (PULSE) [73]) or public health?

ASHA supports incorporating state-level licensure and Medicaid provider status information into the NDH to offer patients access to the broadest range of providers and to speed up the credentialing process. ASHA's Audiology and Speech-Language Pathology Interstate Compact

(ASLP-IC), which will be fully implemented in 2023, can further simplify the acquisition of state-level licensure and practice privilege data from a single source for participating states.

What types of data should be publicly accessible from an NDH (either from a consumer-facing CMS website or via an API) and what types of data would be helpful for CMS to collect for only internal use (such as for program integrity purposes or for provider privacy)?

Data stratification with varying external (public-facing) versus internal (visible only to health plans and government agencies) display status would ensure relevant information for the public while maintaining privacy when needed for providers. ASHA recommends that provider name, credentials, zip code, contact information, payer network status, specialty area, gender, languages spoken, and electronic health record participation be included in the patient facing NDH.

Providers who deliver services via telepractice or in-home/community-based service providers may choose to use their personal addresses as their primary business location. In this instance, limiting address data only to an internal database will safeguard the providers' privacy and eliminate potential safety hazards.

ASHA cautions against including quality scores in the external-facing NDH. The methodology behind quality ratings (e.g., star ratings) can be complex and nuanced and without proper context, these ratings can be misleading to patients. ASHA is opposed to providing links to private provider ranking sites (e.g., Healthgrades, ZocDoc) as Consumer Affairs rates them unfavorably due to inaccurate health care provider information, modified or falsified reviews left by consumers, personal bias, and an inability to properly validate reviews prior to being posted. A 2018 study also notes that, "online consumer ratings of health care providers are highly skewed, fall within narrow ranges, and differ by specialty, which precludes meaningful interpretation by health care consumers."²

We want an NDH to support health equity goals throughout the healthcare system. What listed entities, data elements, or NDH functionalities would help underserved populations receive healthcare services? What considerations would be relevant to address equity issues during the planning, development, or implementation of an NDH?

Providing patients with accurate, centralized provider information will allow patients the broadest possible access to the care they need. Including and allowing online filtering by gender and languages spoken can facilitate patient-provider concordance, which has been shown to improve the patient experience.³

Including contracted health plan status on provider listings can save patients time and build on the work of the No Surprises Act to ensure that patients are not unknowingly presented with costly bills for out-of-network care. In addition, the NDH would be a powerful tool to ensure compliance with network adequacy standards.

How could NDH use within the healthcare industry be incentivized? How could CMS incentivize other organizations, such as payers, health systems, and public health entities to engage with an NDH?

If implemented as a replacement for the existing health care directories, credentialing, and patient-focused databases, the time and administrative burden reduction in and of itself would incentivize providers to participate. The hours saved by entering and confirming information in one central location per stated period could significantly reduce provider burden. In addition, the opportunity to reach a large number of patients in need of services at the same time serves as an opportunity for clinicians looking to develop their practices. An NDH will also support accurate and efficient data exchange by eliminating inaccurate provider information to facilitate interoperability.

ASHA recommends a non-punitive, incentive-based program to populate and/or correct initial data pulled from other systems. This could include incentive payments for completion of the provider entries or the creation of a limited duration all-or-nothing quality measure to include in value-based care arrangements.

How should authentication and access to an NDH be managed for data submission? Should authentication and access processes vary based on the type of data being submitted, and if so, how?

ASHA respects the importance of ensuring data integrity in an NDH through an identity management portal similar to HARP. ASHA recommends including an opportunity for proxy access so administrative staff can fill out and confirm submission information on behalf of the provider(s) they support. The functionality for practice managers to upload spreadsheets containing multiple providers' information at the same time will further the system's efficiency. Another aspect to consider is the ability of the human resources personnel to update the NDH when a provider leaves one health system and joins another to align with interoperability and Fast Healthcare Interoperability Resources (FHIR) standards.

Some current databases are plagued by legacy issues in which outdated information is migrated from other systems leaving providers unable to update their inaccurate record. ASHA suggests that providers can edit any and all data fields given proper identity verification to resolve legacy errors in the NDH.

ASHA encourages the system to be built in such a way that updated information is pushed out to all portions of the database daily to prevent outdated and legacy errors.

How could human-centered design, including equity-centered design, principles be used to optimize the usability of an NDH?

ASHA recommends further engagement with both patients and providers throughout the NDH development process from design through usability testing to ensure optimum navigability and positive user experience.

ASHA encourages the availability of technical support and strong network capabilities to ensure that the website will remain operational even during periods of high user volume. Navigation of

an NDH should also be simple enough for the consumer to explore since technical and health literacy vary greatly among the general public. A 'sandbox' environment where providers can test out the system in advance of full implementation could build support among providers.

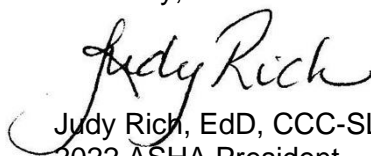
ASHA notes that it is critical for the NDH to include information that is useful and accessible to people with disabilities, including information on the accessibility and modifications made to provider offices. The directory should meet the requirements under Section 508 of the Rehabilitation Act for government websites. The directory should also include information on the physical accessibility of offices and diagnostic equipment. Physical access should be defined as that the office meets the standards for accessible buildings and accessible medical diagnostic equipment published by the U.S. Access Board.^{4,5}

Incorporating an NDH with existing electronic medical record (EMR) systems and aligning with FHIR standards may improve bidirectional data flow between the patient and the provider; thereby, improving quality of care through providers' easy and fast access to patient's EMR and clinical data.

A visual representation of how data will flow throughout the system would be helpful in further understanding the potential benefits and challenges of an NDH.

Thank you for the opportunity to comment in response to this RFI. If you or your staff have any questions, please contact Rebecca Bowen, ASHA's director for Health Care Policy, Value & Innovation, at rbowen@asha.org.

Sincerely,



Judy Rich, EdD, CCC-SLP, BCS-CL
2022 ASHA President

¹ American Speech-Language-Hearing Association. (2021). *ASHA Member and Affiliate Profile 2021*. <https://www.asha.org/siteassets/surveys/2021-member-affiliate-profile.pdf>.

² Daskivich, T., Luu, M., Noah, B., Fuller, G., Anger, J., Spiegel, B. Differences in Online Consumer Ratings of Health Care Providers Across Medical, Surgical, and Allied Health Specialties: Observational Study of 212,933 Providers. *Journal Med Internet Res*. 2018 May 9; 20(5): e176. doi: 10.2196/jmir.9160. PMID: 29743150; PMCID: PMC5980486.

³ Takeshita, J., Wang, S., Loren, A.W., et al. Association of Racial/Ethnic and Gender Concordance Between Patients and Physicians with Patient Experience Ratings. *JAMA Network Open*. 2020;3(11): e2024583. doi:10.1001/jamanetworkopen.2020.24583.

⁴ U.S. Access Board. (n.d.). American with Disability Act Accessibility Standards. <https://www.access-board.gov/ada/>.

⁵ U.S. Access Board. (n.d.). Medical Diagnostic Equipment Accessibility Standards. <https://www.access-board.gov/mde/>.